Primary Care Network

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1 SERVICES

The Primary Care Plan serves a population not previously eligible for Medicaid. The Scope of Service is limited to basic medical service of a general nature to provide preventive and palliative care in an outpatient, office setting. Services in the office should comport with the definition of Primary Care found in Utah Administrative Code R414-100-2(3).

1 - 1 Authority

The Primary Care Plan is authorized by a waiver of federal Medicaid requirements approved by the federal Centers for Medicare and Medicaid Services and allowed under 42 CFR 4.35.1115, 2000-edition. This rule is authorized by Title 26, Chapter 18, Utah Code Annotated.

1 - 2 Definitions

1. "Client" means a person the Division or its duly constituted agent has determined to be eligible for assistance under the Medicaid program.

2. "CLIA" means the Clinical Laboratory Improvement Amendments of 1988.

3. "CMS"means the Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration (HCFA).

4. "Code of Federal Regulation" (CFR) means the publication by the Office of the Federal Register, specifically titled 42, used to govern the administration of the Medicaid program.

5. "Division" means the Division of Health Care Financing within the Department of Health.

6. "Emergency" means the sudden onset of a medical condition, traumatic injury or illness manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

    a) placing the client's health in serious jeopardy;
    b) serious impairment of bodily functions;
    c) serious dysfunction of any bodily organ or part; or
    d) death.

7. "Emergency Department Service" means service provided in a designated acute care general hospital emergency department.

8. "Emergency Service" means:

    a) Attention provided within 24 hours of the onset of symptoms or within 24 hours of making a diagnosis;
    b) A condition that requires acute care, and is not chronic;
    c) It is reimbursed only until the condition is stabilized sufficient that the patient can leave the hospital emergency department; and
    d) It is not related to an organ transplant procedure.

9. "Outpatient" means a client who is not admitted to a facility, but receives services in a private office or clinic.

10. "Outpatient setting" means the physician's office.

11. “Primary Care” means services to diagnose and treat illness and injury as well as preventive health care services. Primary care promotes early identification and treatment of health problems, which can help to reduce unnecessary complications of illness or injury and maintain or improve overall health status.

12. “Primary Care Provider System” means those services provided directly by the physician or by his staff, under his supervision in the office.

13. “Provider” means any person, individual, corporation, institution or organization, qualified to perform services available under the Medicaid program and who has entered into a written contract with the Medicaid program.

2 SCOPE OF SERVICE

2 - 1 Physician Services

Physician services provide for the basic medical needs of eligible individuals and must be provided within the parameters of accepted medical practice. Physician services may be provided directly by the physician or by other professionals – licensed certified nurse practitioners, or physician assistants, authorized to serve the health care needs of the practice population through an approved scope of service under the physician's supervision.

Providers of Primary care service are limited to those physicians who are prepared in:
Family Practice,
General Practice,
Internal Medicine,
Obstetrics and Gynecology, and
Pediatrics.
In addition, providers of physician services in Federally Qualified Health Centers, Rural Health Clinics, Local Health Department clinics, and Health Clinics of Utah can provide service based on the Scope of Service and codes developed for the Primary Care Network program.

Physician services include those that can be performed in an outpatient setting.

1. The CPT Manual is the standard for defining and coding physician services. Under the provisions of this Plan, not all procedures are acceptable, e.g., experimental, cosmetic, or those not reasonable, medically necessary or cost effective. Nonspecific or unlisted codes require physician review because of the potential for use to cover otherwise non-covered services.

2. The Approved Medical and Surgical Procedures for the Primary Care Plan with Pertinent Criteria ("PCN - CPT Code List") is implemented into this program. This list serves as a guide as well as a safeguard to inappropriate utilization. The list outlines those procedures which are excluded because they are experimental, ineffective, cosmetic, or not reasonable and medically necessary. (List attached.)

3. The CPT office visit, Evaluation and Management codes (99201 - 99215) for either new or established patients are appropriate for the office services claims under this plan.

4. In general, both office visit and service codes will not pay for same dates of service.

5. Licensed certified family or pediatric nurse practitioners are limited, under this Medicaid Scope of Practice, to a cooperative, ambulatory, office type, working relationship with a physician. When employed by the physician, the physician bills for the service.

6. Physician assistants work under the supervision of a physician to provide service to patients within the practice population.

7. Physicians providing service in the Emergency Department will use CPT Codes 99281 - 99285 to bill for services.

2 - 2 Limitations for Physician Services

1. The CPT Manual is the standard for defining and coding physician services. However, not all procedures are covered under this plan, e.g., experimental, ineffective, cosmetic, or those not cost effective, reasonable or medically necessary.

2. Use of nonspecific or unlisted codes to cover procedures not otherwise listed in the CPT Manual require Medicaid physician consultant review and approval because of the potential for use to cover otherwise non-covered services.

3. Services are limited to those included in the "PCN - CPT Code List" with criteria.

4. Evaluation/Management office visit codes (CPT) for new and a (99201 - 99215) must be used appropriately on claims for service.

5. Office visit codes (E/M) and service codes (10060 - 69990) will not be paid on the same date of service.

6. Services identified by the 90000 series of codes are specialty medical services and will be limited only to those that can be safely provided in the physician's office.

7. After-hours office visit codes cannot be used in a hospital setting, including emergency department, by private or staff physicians. They cannot be used for standby for surgery, delivery, or other similar circumstances, and they cannot be used when seeing a new patient.

8. Cognitive services are limited to one service per day by the same provider.

9. Modifier 25 will not be recognized as a stand-alone entity to override the one service per day limitation.

10. Laboratory services provided by a physician in the office are limited to the approved kits, waived tests or those laboratory tests identified by CMS for which an individual physician is CLIA certified to provide and listed in the "PCN -CPT Code List."

11. A specimen collection fee is limited only to venipuncture specimens drawn under the supervision of a physician to be sent outside of the office for processing. Any blood test obtained by heel or finger stick will post a mutually exclusive edit with 36415 –venipuncture. The following codes have been added as mutually exclusive to 36415: 82948–blood glucose, reagent strip, 85013–spun hematocrit, 85014–hematocrit, 85610–Prothrombin time, 83036–glycated hemoglobin, and 86318 –immunoassay for infectious agent by reagent strip when submitted with the modifier QW.

12. Over-the-counter drugs and medications are limited to those on the list of covered OTC drugs established for this plan. Refer to Chapter 2 - 6, Pharmacy Services.

13. Vitamins are limited to coverage for pregnant women. Vitamin B-12 is limited to patients with pernicious anemia.

14. Drugs and biologicals are limited to those approved by the Food and Drug Administration or the local Drug Utilization Review Board which has the authority to approve off label use of drugs.
    The pneumovax vaccine **must be separated by more than five years.** When given sooner than five years, there are adverse reactions which may occur from this vaccine. For updates on adult vaccination visit the Centers for Disease Control and Prevention web site at http://www.cdc.gov/nip/recs/adult-schedule.pdf

15. Additional payment for services is limited to those cases where the circumstances are so unusual and severe that excess time is required to safely monitor and treat the patient. Documentation in the medical record must clearly show the extenuating circumstances and the unusual time commitment to warrant medical review and consideration for additional reimbursement.

16. Medical and Surgical Procedures identified by CPT code may only be provided by the physician or osteopath. Procedures may not be completed by ancillary personnel including nurse practitioners and physician assistants.

2 - 3 Hospital Services

The Primary Care Plan **does not cover** inpatient or outpatient hospital services except for emergency services in a designated acute care general hospital emergency department.

Revenue Codes and ICD.9.CM diagnosis codes are the main means of documentation for these services. Revenue Codes appropriate to be covered for emergency service are:

Emergency Room	450, 458, 459
Laboratory	300, 302, 305, 306, 309, 925, 929
Radiology	320, 324, 329
EKG/ECG	730, 739
Respiratory Therapy Services	410
Inhalation Therapy	412, 419
Cast Room	700,709
Observation/Treatment Room	760, 761, 762, 769
Pharmacy (medications used in ED)	250, 260, 269
IV Solutions	258
Med-Surg Supplies (use in ED only)	270

All other revenue codes are non-covered.

In addition, the current Medicaid Authorized Diagnoses for Emergency Department Reimbursement list is incorporated as approved emergency department care. Any code other than one of those listed would be a non-covered service resulting in no payment being made. If the determination is made that the visit is not for a bonafide emergency, and no service is provided, revenue code 485 (Triage fee) can be billed and a nominal payment can be made to the hospital for the evaluation and determination. The diagnoses in the Authorized Emergency Department list are ICD.9.CM codes. (List Attached.)

Physicians providing service in the Emergency Department will use CPT Codes 99281 - 99285 to bill for services.

2 - 4 Minor Surgery and Anesthesia in an Outpatient Setting

For the purposes of this program, outpatient setting means only in the physician's office. Only those procedures that can be safely provided in the physician's office can be covered.

2 - 5 Laboratory and Radiology Services

Professional and technical laboratory and radiology services are furnished by certified providers with use of the 70000 and 80000 series of codes.

1. For this program, laboratory and radiology procedures will be limited to those which can be provided through the "Primary Care Provider system," i.e., in the physician's office.

2 Laboratory services are limited under federal CLIA regulations. All laboratory testing sites providing services must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Only laboratories CLIA certified can complete certain tests and receive payment. (CLIA List attached.)

3. Some laboratory and radiology procedures are non-covered because they relate to otherwise non-covered services. The "PCN -CPT Code List" indicates covered service.

4. CPT code 80074, acute hepatitis panel, includes four other codes: 86709, 86705, 87340, and 86803. When three of the four codes are billed, they will be rebundled into the acute hepatitis panel code 80074 for payment.

2 - 6 Pharmacy Services

The Medicaid Pharmacy Policy as set forth in the Utah Provider Manual for Pharmacy Services is hereby adopted for the Primary Care group of clients with the following changes. Coverage is more restrictive for units and time.

Pharmacy services include prescribed drugs and preparations provided by a licensed pharmacy. The fact that a provider may prescribe, order, or approve a prescription drug, service, or supply does not make it an eligible benefit, even though it is not specifically listed as an exclusion. The following pharmacy benefits and restrictions are incorporated into this program.

1. Drug Limitations and Benefits

   A. This program is limited to four prescriptions per month, per client with no overrides or exceptions in the number of prescriptions.
   B. OTC prescriptions count against the 4RX/month limit.
   C. A patient paid prescription is not counted as one of the four prescriptions per month.
   D. The copay is product dependent:
      (1) $5.00 copay for any generic product.
      (2) $5.00 copay for the preferred drugs on the attached list.
      (3) $5.00 copay for OTC products.
      (4) 25% of the Medicaid payment for any name brand drug not on the preferred list where a generic product is NOT available.
      (5) 25% of the Medicaid payment for any product that is in the same therapeutic class as a product on the Preferred Drug List.
   E. When a generic product is available and the name brand is requested and the name brand is NOT on the preferred list, the total payment must be made by the client.
   F. Prior approval and the criteria governing such are the same as the regular Medicaid program.
   G. Generic drugs with an A B rating are mandated for dispensing.
   H. Name brand drugs where generics are available will require full payment by the client. No physician DAW is available.
   I. Over-the-counter products. The extent of these products is more limited than regular Medicaid. Products covered are: Insulin 10cc vials; Insulin syringes; glucose blood test strips; lancets; contraceptive creams, foams, tablets, sponges, and condoms.
   J. OTC products that are covered require a written prescription just like legend drugs in order for the pharmacy to fill them.

2. Exclusion and Restrictions

   A. No duplicate prescription will be paid by Medicaid for lost, stolen, spilled or otherwise non usable medications.
   B. No injectable products are available for payment by Medicaid except for 10 ml vials of Insulin.
   C. Compounded prescriptions are not covered.
   D. Drugs are covered for labeled indications only.
   E. Rapidly dissolving tablets, lozenges, suckers, pellets, patches, or other unique formulations or delivery methodologies are NOT available. Patches are NOT reimbursable.
   F. Cosmetics, weight gain or loss products are not covered.
   G. No vitamins or minerals are covered, except for pregnant women.

*

3. Cumulative monthly amounts are determined for the following drugs:

   - Carisoprodol (Soma) - 120
   - Lactulose 1920
   - Miralax 1054 grams
   - Narcotic/APAP - 180
   - PPIs - 31 with prior approval for override
   - Preven - 2
   - Stadol NS - 10
   - Tryptans (for migraine headache) - 9
   - Ultram 180
   - Ultracet 180 (focus on APAP, therefore included in narcotic/APAP 180 cumulative limit)
   - Viagra - 5

4. Drugs Requiring Prior Approval:

   Drugs on the current Drug Criteria and Limits List require prior approval. List attached.

2 - 7 Durable Medical Equipment and Supplies

Equipment and appliances are necessary to assist the patient's medical recovery, including both durable and non-durable medical supplies and equipment. However, the Waiver notes that "The fact that a provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion."

The following codes represent covered equipment and supplies under this plan:

A4259; A6430; A6434; A4565; A4490 - A4510; A4253; E0114; E0135 LR; A4570; A4614; Y6050 LR; K0001 LR; L0120; S8490.

2 - 8 Preventive Services and Health Education

The Plan includes preventive screening services, including routine physical examinations and immunizations, and educational methods and materials for promoting wellness, disease prevention and management.

These services are assumed under the general Evaluation and Management care provided to patients by the physician during medical visits. The services include counseling, anticipatory guidance, and/or risk factor reduction interventions. Except for immunization codes, no special programs or codes are covered. The intent is that these services be billed under the general evaluation and management codes and a co-pay should be collected.

90471 - 90473 Administration fee

Covered Immunization Agents:

90740 Hepatitis B vaccine for immunocompromised adult or adult dialysis patient
90746 Hepatitis B adult
90632 Hepatitis A adult
90636 Hepatitis A and Hepatitis B combination for adult
90659 Influenza virus vaccine whole, for IM or jet injection use
90718 Tetanus and diphtheria toxoids (Td) This should be main choice because of resurgence of diphtheria in Europe.
90703 Tetanus toxoid
90675 Rabies IM for post exposure treatment
90707 MMR vaccine
90716 Varicella for subcutaneous use for a varicella-exposed person who is not immune, but not for use in immunocompromised patient.
90732 Pneumococcal polysaccharide 23-valent vaccine adult or immunosuppressed patient
90665 Lyme disease only if known exposure.

2 - 9 Family Planning Services

This service includes disseminating information, treatment, medications, supplies, devices, and related counseling in family planning methods to prevent or delay pregnancy. All services must be provided or authorized by a physician, or nurse practitioner and must be provided in concert with Utah law. Refer to Chapter 2 - 17, Non Covered Services under the Primary Care Plan.

2 - 10 Vision Care

Services provided by licensed ophthalmologists or licensed optometrists, within their scope of practice. Covered services are limited to:

1. examinations. No glasses will be covered.
2. one exam every 12 months.

The following codes are covered: 92002, 92004, 92012, 92014

2 - 11 Dental Services

Services include relief of pain and infection for dental emergencies limited to an emergency examination, an emergency x-ray, and emergency extraction when the service is provided by a dentist in the office. Only the following dental codes are covered:

D0120 Periodic exam - 2 per year, no sooner than 6 months apart
D0140 Limited exam, focused problem (emergency examination)
D0150 Comprehensive oral exam, one per provider
D0210 Intra oral complete series - including bitewings, total of 8 or more films
D0220 Periapical x-ray 1 film
D0230 Periapical x-ray additional film
D0270 Bitewing single
D0272 Bitewing 2 films
D0274 Bitewing 4 films
D1110 Adult prophy
D1205 Topical fluoride application
D4355 Debridement for diagnosis - instead of prophy, one per year
D2140 Amalgam 1 surface permanent
D2150 Amalgam 2 surface permanent
D2160 Amalgam 3 surface permanent
D2161 Amalgam 4+ surface permanent
D2330 Resin 1 surface anterior
D2331 Resin 2 surface anterior
D2332 Resin 3 surface anterior
D2335 Resin 4+ surface anterior
D7140, Extraction, erupted tooth or exposed root (elevation and/or forceps removal).
D7210 Extraction surgical, document need to lay flap, section tooth

2 - 12 Transportation Services

Ambulance (ground and air) service for medical emergencies only.

The following codes are covered.
A0425, A0429, A0430, A0431.

2 - 13 Interpretive Services

Services **provided by entities under contract to Medicaid** to provide medical translation service for people with limited English proficiency and interpretive services for the deaf.

No specific codes are identified. When providers use the Medicaid authorized interpretive services, payment is made to the entity under terms of the signed contract. Medical providers may use their own interpreters. However, independent interpreters cannot bill nor be paid by Medicaid. If independent interpreters are used, payment remains the responsibility of the provider who secured their services.

2 - 14 Audiology Services

Audiology services are limited to one hearing test for hearing loss annually.
V5010, assessment of hearing aid.
Hearing aids are not a covered benefit.

3 Non Covered Services under the Primary Care Network

1. Inpatient or outpatient hospital diagnostic, therapeutic, or surgical services, except for those in the emergency department or those very minor procedures which can be provided in the physician's office.

2. Procedures that are cosmetic, experimental, investigational, ineffective or not within the limits of accepted medical practice.

3. Health screenings or services to rule out familial diseases or conditions without manifest symptoms.

4. Routine drug screening.

5. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, or for insurance or employment examinations.

6. Non-emergency ambulance service through common or private aviation services.

7. Transportation service for the convenience of the patient or family.

8. Family planning services - Non-covered:

   – Norplant: CPT procedure codes 11975, 11976, 11977

   – Infertility studies and reversal of sterilization:
   ICD.9.CM Diagnosis Codes: Male - 606.0 - 606.96
   CPT Procedure Codes: 54240, 54250, 54900, 54901, 55200, 55300, 55400.

   ICD.9. CM Diagnosis Codes: Female - 256.0 - 256.9; 628.0 - 628.9
   CPT Procedure Codes: 58345, 58350, 58750, 58752, 58760, 58770

   – Assisted Reproductive Technologies (ART's) (in-Vitro)
   ICD.9.CM diagnosis code: V26.1 and above infertility diagnosis codes.
   ICD.9.CM procedure codes: 66.1, 66.8, 69.92, 87.82, 87.83.
   CPT procedure codes are: 58321, 58322, 58323, 58970, 58974, 58976, 89250, 89251, 89252, 89253, 89254, 89255, 89256, 89257, 89258, 89259, 89260, 89261, 89264, 89321

   – Genetic Counseling
   ICD.9.CM diagnosis code: V26.3, V65.40, V25.09
   CPT Procedure codes for cytogenetic studies: 88230 - 88299

9. Abortion

10. Sterilization

11. Weight loss programs

12. Office visit for allergy injections or other repetitive injections - Non-covered:

   – CPT procedure codes 95115 through 95134

   – CPT procedure codes 95144 through 95199

13. Vitamins - prescription or injection

14. Physical Therapy

15. Occupational Therapy

16. Massage Therapy - Non-covered:

    – CPT Procedure code 97124

17. Podiatric (podiatry) Services - Routine foot care

18. Stage Renal Disease (Dialysis)

19. Medical and surgical services of a dentist

20. Organ Transplant Services

21. Charges incurred as an organ or tissue donor

22. Home Health and Hospice Services
    This exclusion applies regardless of whether services are recommended by a provider and includes the following:
    Skilled Nursing Service
    Supportive maintenance
    Private duty nursing
    Home health aide
    Custodial care
    Respite Care
    Travel or transportation expenses, escort services, or food services

23. Mental health

24. Substance abuse and dependency services

25. Hypnotherapy or Biofeedback

26. Long Term Care

27. Diabetes Education

28. HIV Prevention

29. Home and Community-based Waiver services

30. Targeted case Management

31. Other outside medical services in free standing centers – Emergency centers (Insta-Care type), surgical centers, or birthing centers

32. Services to children (CHEC)

33. Chiropractic Services

34. Speech Services

Note: Any ICD.9.CM diagnosis or procedure codes related to any of the services in the preceeding PCN Plan *Non-Covered Services List* will also be non-covered. Payment of such services will be denied.

35. Pregnancy Related Services

A. Prenatal Services

59000	Amniocentesis; diagnostic	59001	Amniocentesis; therapeutic
59012	Cordocentesis	59015	Chorionic villus sampling
59020	Fetal stress test	59025	Fetal non-stress test
59030	Fetal scalp sampling	59050- 59051	Fetal monitoring during labor
59100	Hysterotomy (Reqs PA)	59120 - 59121	Ectopic Pregnancy
59130	Abdominal Pregnancy	59135 - 59136	Interstitial pregnancy
59140	Cervical pregnancy	59150 - 59151	Ectopic Pregnancy (Laparoscopy)
59320 and 59325	Cerclage of cervix	59350	Hysterorrhaphy

B. Vaginal Delivery, Antepartum, and Postpartum care

59400	59400 global	59409	Delivery only
59410	Delivery with post partum care	59412	Version
59414	Delivery of placenta	59425 - 59426	Antepartum care only
59430	Post partum care only	59300	Episiotomy
59160	Postpartum D&C		

C. Cesarean Delivery

59510, 59514, and 59515 59525 hysterectomy following delivery (emergency)

D. Delivery after Previous C-section

59610, 59612, 59614, 59618, 59620, 59622

E. Abortions and Sterilizations

55250	55450	55530	55535	55540	55550	55600	55605	55650	58563	58600	58605
58611	58615	58661	58670	58671	59100	59840	59841	59850	59851	59870	59852

F. Other pregnancy related medical procedures

59866	Multi fetal pregnancy reduction	59870	Molar pregnancy
59871	Removal of cerclage suture	59898	Unlisted services/procedures
59899	Unlisted services/procedures		
76805 - 76857	Ultrasounds		

G. High Risk and Enhanced Services

Y7005 and Y7006 Risk Assessment

H. High Risk Delivery(s) **To be covered and billed only by a physician.**

Y7050	Global (vaginal)	Y7051	Global (C-section)
Y7052	Delivery and Post Partum care only	Y7053	C-section and Post Partum care only

I. Enhanced Services - (**These are the services added under the "Baby your Baby" Program). These services are provided by nurses, midwives, agencies or ancillary providers.

Y7000, Y7030, Y7010, Y7020, Y7025
Single Visits Y7040 and Y7045
(Could be provided either by physician or nurse midwife.)

J. Certified Nurse Midwife Services

The following services were developed for CNMs who are in a private practice and would be covered in addition to any codes mentioned above for the CNM.

Y0616 - Y0622 Office visits for well-woman care
Y0623 - Y0625 Contraceptive management
Y0600 - Y0608 Global maternity care - antepartum and post partum only care

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